Physician Related Services

Provided by:

Physicians, Mid-Level Practitioners, Podiatrists, Laboratories, Imaging Facilities, Independent Diagnostic Testing Facilities, and Public Health Clinics

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

July 2004

This publication supersedes all previous Physician, Mid-Level Practitioner, Podiatrist, Laboratory, Imaging Facility, Independent Diagnostic Testing Facility, and Public Health Clinic provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2002.

Updated September 2002, January 2003, June 2003, August 2003, September 2003, December 2003, July 2004.

My Medicaid Provider ID Number:

My CHIP Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client's designated provider.

PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Program Officer

Send inpatient stay documentation to:

PASSPORT Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

CLIA Certification

For questions regarding CLIA certification call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Lab and X-ray (continued)

Claims for multiple x-rays of same type on same day, send to:

DPHHS
Lab & X-ray Services
Health Policy & Services Division
P.O. Box 202951
Helena, MT 59620

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

(406) 444-3993 Phone

For clients with last names beginning with M - Z, call:

(406) 444-0190

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services, or emergency department reveiws, contact:

Phone:
(800) 262-1545 X150 In state
(406) 443-4020 X150 Out of state and Helena

Fax:
(800) 497-8235 In state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.state.mt.us/hpsd/medicaid/medrecip/medrecip.htm	• Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Health Policy and Services Division (Now Child and Adult Health Resources Division) www.dphhs.state.mt.us/hpsd	• **Medicaid:** See list under **Provider Information Website** above, and Client Information is available also • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** CAHRD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.

Key Web Sites (continued)

Web Address	Information Available
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this web-site for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

All forms required for abortions can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or downloaded from the *Provider Information Web Site* (see *Key Contacts*).

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

Cosmetic services (ARM 37.86.104)

Medicaid covers cosmetic services only when it can be demonstrated that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid does not cover surgical reconstruction following breast cancer and reshaping breast structure to improve appearance. Before cosmetic services are performed, they must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Services are authorized on a case-by-case basis.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages (see the *EPSDT* chapter in this manual). Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.

Family planning services (ARM 37.86.1701)

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the PASSPORT provider is not required for family planning services. See the *Completing a Claim* chapter in this manual for PASSPORT overrides. Specific billing procedures must be followed for family planning services (see *Billing Procedures*).

Home obstetrics (ARM 37.85.207)

Home deliveries are only covered on an emergency basis (see *Definitions*) by a physician or licensed midwife.

Immunizations

The Vaccines For Children (VFC) Program makes available at no cost to providers selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization Program at (406) 444-5580.

Medicaid does not cover pneumonia and flu vaccines for clients with Medicare Part B insurance because Medicare covers these immunizations.

Infertility (ARM 37.85.207)

Medicaid does not cover treatment of infertility.

Prescriptions (ARM 37.86.1102)

- Drugs are limited to a 34-day supply.
- No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
  - Antibiotics
  - Schedule II and III drugs
  - Antineoplastic agents

- Compounded prescriptions
- Prescriptions for suicidal patients or patients at risk for drug abuse
- Topical preparations
- Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations

- The DUE CARE board has set monthly limits on certain drugs. Use over these amounts requires prior authorization. Only one migraine medication may be prescribed within a month. Refer to the *PASSPORT and Prior Authorization* chapter in this manual for limits.

Routine podiatric care

Medicaid pays for routine podiatric care when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires treatment by a physician or podiatrist. Routine podiatric care includes the following:

- Cutting or removing of corns and calluses
- Trimming of nails
- Application of skin creams
- Debridement of nails
- Other hygienic or preventive maintenance care

Sterilization (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

   The 30-day waiting period may be waived for either of the following reasons:

   - **Premature Delivery**. The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
   - **Emergency Abdominal Surgery**. The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.

2. Client must be at least 21 years of age when signing the form.

All forms required for sterilizations can be copied form *Appendix A: Forms*, downloaded from the Provider Information Website, or ordered from Provider Relations (see *Key Contacts*).

Medicaid covers hysterectomies only when they are a result of a procedure performed to address another medical problem, not when the primary purpose is to render the client sterile.

3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.

4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

A notation *"Not a Sterilization"* on a claim is not sufficient to fulfill these certification requirements.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date section A of this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

Surgical services

- The fee schedule shows Medicaid policies code by code on global periods, bilateral procedures, assistants at surgery, co-surgeons, and team surgery. These policies are almost always identical to Medicare policies but in cases of discrepancy the Medicaid policy applies.
- Medicaid only covers "assistant at surgery" services when provided by physicians or mid-level practitioners who are Medicaid providers.
- Medicaid does not cover surgical technician services.
- See the *Billing Procedures* chapter regarding the appropriate use of modifiers for surgical services.

Telemedicine services

- Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid.
- The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult.
- Medicaid does not cover network use charges.

Transplants

All Medicaid transplant services must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Medicaid covers the following transplant services:

- For clients 21 years or older: only bone marrow, kidney, or cornea transplants.
- For clients less than 21 years old: all transplants that are covered by Medicare that are not considered experimental or investigational.

Weight reduction

- Physicians and mid-level practitioners who counsel and monitor clients on weight reduction programs can be paid for those services. If medical necessity is documented, Medicaid will also cover lab work. Similar services provided by nutritionists are not covered for adults.
- Medicaid does **not** cover the following weight reduction services:
  - Weight reduction plans or programs (e.g., Jenny Craig, Weight Watchers, etc.)
  - Nutritional supplements
  - Dietary supplements
  - Health club memberships
  - Educational services of a nutritionist
  - Gastric bypass

Emergency department visits

The Department covers emergency services provided in the emergency department. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Beginning August 1, 2003, a service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of the Department's pre-approved emergency diagnosis codes is available on the Provider Information website under *Emergency Diagnosis Codes* (see *Key Contacts*).
- The service did not meet one of the previous two requirements, but the medical professional rendering the medical screening and evaluation believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the services must be mailed to the emergency department review contractor (see *Key Contacts*).

If the visit does not meet one of the emergency criteria, then services beyond the screening and related diagnostic tests are not reimbursed and cost sharing should be collected. If the visit meets the emergency criteria, cost sharing is not collectible.

If an inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider. If the hospital attempts to contact the PASSPORT provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation that clearly shows the time of the attempt to reach the PASSPORT provider and the time of the initiation of post stabilization treatment must be sent to the PASSPORT program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60 minute time lapse between these two events.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

Clients who are enrolled in MHSP have limited coverage for physician-related services. See the *Mental Health Services Plan* manual.

For Medicaid clients seeking mental health services, the information in this chapter applies to mental health services just as it does for physical health services.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction Mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/ out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/ out-of-state
	
	Fax:
	(406) 444-0778
		• Both the Referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Prescription Drugs

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix and have a contraindication to aspirin.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	• Requests exceeding these quantity limits will be considered on an individual basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	The patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Vioxx (rofecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy Vioxx 50mg is not recommended for chronic use. Medicaid does not cover Vioxx at this dose for extended periods.
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.

Disease-Modifying Anti-Rheumatic Drugs (DMARD)
 	
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Failure with or contraindication to methotrexate alone or in combination with sulfasalazine, hydroxychloroquine or Arava, in which case Enbrel, Remicade, or Kineret may be approved either alone or in combination with Arava.
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel whether alone or in combination with methotrexate.
	  • Enbrel or Remicade may be approved with Arava on an individual basis.
	  • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • $\geq$ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
	  • Remicade therapy will only be approved following a negative TB test

Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, Carafate and Cytotec Prior authorization is required only for concomitant usage of an H2-antagonist, a proton pump inhibitor, cytotec, or carafate. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. **Turner's Syndrome:** Chromosomal abnormality showing Turner's syndrome. **Growth hormone deficiency in adults:** • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Hypnotic Drugs Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Migraine Headache Drugs For monthly quantities greater than 9 tablets: Imitrex (sumatriptan): 4 injections (2 kits) **or** 6 units of nasal spray Maxalt (rizatriptan) Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan) Zomig nasal spray 6 units Migranal (dihydroergotamine): 4 units Axert (almotriptan) Frova (frovatriptan) Relpax (electriptan) Amerge (naratriptan HCl)	Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Usage of duplicating generic entities are not allowed, but authorization may be approved on an individual basis for concomitant use of differing dosing formulations of the same drug. Concurrent therapy with Stadol will not be covered.
Nonsedating antihistamine products	• Prescribed OTC Loratadine products whose manufacturer has a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) will be available to clients without prior authorization (PA) restrictions. • PA required for federal legend brand and generic non-sedating antihistamines. PA may be authorized upon failure of a fourteen day trial of OTC Loratadine products
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Oxycodone HCL Controlled-Release (OxyContin)	Prior authorization is required for all dosing above twice a day and above 320 mg per day.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of intermittent claudication as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.
Proton Pump Inhibitors (PPI's) Prevacid NapraPac	Federal legend, brand and generic Proton Pump Inhibitors (PPI's) may be authorized upon failure of Prilosec OTC 20mg at doses that exceed 40mg per day. Special consideration may be given on an individual basis for patients requiring specific dosing regimens based on the various PPI formulations. Requires that the patient must have tried and failed concomitant use of Prilosec OTC and Naproxen.
Smoking Cessation Drugs Nicotine-replacement products. Patches are the preferred course of therapy. The gum, lozenge and inhaler replacement therapies are only authorized for patients having allergies or intolerance to the patch adhesive. Zyban (buproprion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

PA Criteria for MHSP Prescription Drugs

Drug	Criteria
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder. • Intolerance, contraindication, or partial response to Lithium, Tegretol, or Depakote.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be innappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health Services Plan* manual.

For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. The CHIP Dental manual and additional CHIP information are available on the *Provider Information* web site (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage though Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility information may list other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is listed on the eligibility verification. If a client has other coverage (excluding Medicare), it will be shown also. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility information.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicaid has not made arrangements with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B crossover claims

Medicare Part B covers outpatient hospital care, physician care and other services. Although outpatient hospital care is covered under Part B, it is processed by Medicare Part A. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.

Submitting Medicare claims to Medicaid

When submitting a claim to Medicaid, include the Medicare EOMB and use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

Remember to submit Medicare crossover claims to Medicaid only:

- When the referral to Medicaid statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.
- When Medicare denies the claim.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, the providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- Some prenatal and pediatric diagnosis codes can be billed to Medicaid first (see following table). In these cases, Medicaid will "pay and chase" or recover payment itself from the third party payer.

Diagnosis Codes That May be Billed to Medicaid First	
ICD-9-CM Prenatal Codes	**ICD-9-CM Preventive Pediatric Codes**
V22.0	V01.0 – V01.9
V22.1	V02.0 – V02.9
V23.0 – V23.9	V03.0 – V06.9
V28.0 – V28.9	V07.0 – V07.9
640.0 – 648.9*	V20.0 – V20.2
651.0 – 658.9*	V70.0
671.0 – 671.9	V72.0 – V72.3
673.0 – 673.8	V73.0 – V75.9
675.0 – 676.9	V77.0 – V77.7
	V78.1 – V78.3
	V79.2 – V79.3
	V79.8
	V82.3 – V82.4
* In these two ranges, the code only qualifies for the exemption if the fifth digit is a 3 (e.g. 670.13 or 648.93).	

- The following services may also be billed to Medicaid first:
  - Nursing facility (as billed on nursing home claims)
  - Audiology
  - Hearing aids and batteries
  - Drugs (as billed on drug claims)
  - Personal assistance
  - Transportation (other than ambulance)
  - Optometry
  - Oxygen in a nursing facility
  - Dental (as billed on dental claim)
  - Home and community based services (waiver)
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid *assignment of benefits* (see *Definitions*), the provider must submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "amount paid" field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, include a copy of the denial (including the reason explanation) with the claim, and submit to Medicaid.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Other Programs

The information covered in this chapter also applies to clients enrolled in the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) dental and vision providers only.

Billing Tips for Specific Services

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Anesthesia

- Use appropriate CPT-4 anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes on the claim. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the claim as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in on the claim (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the EPSDT chapter in this manual.
- For EPSDT overrides on limits and cost sharing, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

For family planning overrides on cost sharing, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use code 90471 with modifier SL to bill for the administration of vaccines under the Vaccines for Children (VFC) program. Use 90472-SL for subsequent VFC administrations.
- There must be a VFC covered code for each unit of service billed with code 90471-SL and 90472-SL. For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580.
- No more than four diagnosis codes are necessary.
- Bill each VFC code with $0.00 charges.

For example, a provider administers three vaccines: MMR, pneumococcal conjugate, and DTaP.

24. A						B	C	D		E	F		G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1 12	12	03	12	12	03	11	0	90471	SL	1	10	00	1				
2 12	12	03	12	12	03	11	0	90472	SL	1	20	00	2				
3 12	12	03	12	12	03	11	0	90707		1	0	00	1				
4 12	12	03	12	12	03	11	0	90669		1	0	00	1				
5 12	12	03	12	12	03	11	0	90700		1	0	00	1				

Obstetrical services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date Section A of this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
    - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
        - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
        - The reason for the hysterectomy was a life-threatening emergency.
        - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

Surgical services

- Medicaid does not provide additional payment for the "operating room" in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.

- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
    - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.
    - When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
    - When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

  Medicaid edits for some surgical services using Medicare's Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.
- ***Assistant at surgery***
    - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
    - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
    - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.
    - Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- ***Global surgery periods:*** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
    - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
    - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.

- For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
- If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.
- In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number on the claim (field 23 on the CMS-1500 claim form). See the *Completing a Claim* chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA)

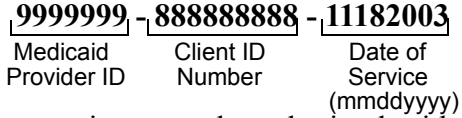
transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.

- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:



The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Common Billing Errors (continued)	
Reasons for Return or Denial	**How to Prevent Returned or Denied Claims**
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used to override copayment and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Overrides

Code	Client/Service	Purpose
1	EPSDT	Overrides benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the **line**

- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number (UPIN).
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix C*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only six weeks on MEPS.

If a claim was denied, please read the reason and remark code description before taking any action on the claim.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

JOHN R. SMITH MD
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/04 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010304	010304	1	99212	35.00	29.20	Y	
(9) ICN	00404011250000700								
		LESS MEDICARE PAID*******					26.25		
		LESS COPAY DEDUCTION**					1.46	(17)	
		CLAIM TOTAL*******				35.00	1.49		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020104	020104	1	99213	45.00	0.00	N	
ICN	00404011250000800								
		020304	020304	1	99214	60.00	0.00 (17)	N	
		CLAIM TOTAL*******				105.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020404	020404	1	99213	45.00	0.00 (17)	N	133
ICN	00404011250000900	020504	020504	1	99214	60.00	0.00	N	133
		CLAIM TOTAL*******				105.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The credit balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim to Medicaid (not an adjustment).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or include insurance denial information with the corrected claim, and submit to Medicaid.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

Adjustments can only be made to paid claims.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
Dr. John R. Smith, MD
Name
123 Medical Drive
Street or P.O. Box
Anytown, MT 59999
City State Zip

2. CLIENT NAME
Jane Doe

3. INTERNAL CONTROL NUMBER (ICN)
00204011250000600

4. PROVIDER NUMBER
1234567

5. CLIENT ID NUMBER
123456789

6. DATE OF PAYMENT 02/15/02

7. AMOUNT OF PAYMENT $ 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/02	01/23/02
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/02

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the *Provider Information* web site (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website • Provider's bank • Division of Payment Management web site (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion (see *Key Contacts*) • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) vision and dental services only.

Professional differentials

For some services, mid-level practitioners are paid at 90% of the fee schedule amount. For other services, however, mid-level practitioners are paid at 100% of the fee schedule amount. The 100% services include immunizations, family planning, drugs paid via HCPCS Level II codes, services to clients under age 21 (i.e., EPSDT services), lab and pathology services, radiology, cardiography and echocardiography (per ARM 37.86.205(6)).

Psychiatrists are paid 125% of the fee schedule for mental health and related services. Licensed professional counselors and social workers are paid 62.5% of the fee schedule.

Charge cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by report

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider's charge. As of July 2002 the percentage was 51%; the Department typically reviews this percentage each July.

Bundled codes

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Examples are removal of sutures (15850), pulse oximetry (94760) and post-operative follow-up visits (99024). Because these services are covered by Medicaid, providers may not bill clients for them on a private pay basis.

Status codes

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

Table A
Medicare and Medicaid RBRVS Status Values

Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered

Notes:
- Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X.
- Medicare uses the label "injections" for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day.

Anesthesia Services

The following payment method is used for anesthesia services (00100-01999), regardless of whether the service is billed by an anesthesiologist or another professional. Though the method differs from the RBRVS payment method, the two methods are linked and contain similar provisions.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (i.e. salpingo-oophorectomy, orchiectomy, etc.) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy before it was performed. The client and the physician complete this portion of the form together with an interpreter if applicable. The client must sign and date this form at least 30 days prior to the hysterectomy. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or her representative must sign and date the form at least 30 days prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form.
4. If interpreter services are used, the interpreter must sign and date the form at least 30 days prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in conjunction with Section A in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy **Please Type or Print**

PATIENT NAME (Last) (First) (Initial)		PATIENT MEDICAID I.D. NUMBER	DATE OF BIRTH
			MONTH DAY YEAR
PHYSICIAN PROVIDER #	PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST	
		FROM	TO
PHYSICIAN NAME		MONTH DAY YEAR	MONTH DAY YEAR
PHYSICIAN STREET ADDRESS		**MAIL, FAX OR PHONE COMPLETED FORM TO:**	
PHYSICIAN CITY STATE ZIP		**DRUG PRIOR AUTHORIZATION UNIT MOUNTAIN-PACIFIC QUALITY HEALTH 3404 COONEY DRIVE HELENA, MT 59602 (406) 443-6002 or 1-800-395-7961 (PHONE) (406) 443-7014 or 1-800-294-1350 (FAX)**	
PHARMACY PROVIDER NO.	PHARMACY PHONE #		
PHARMACY NAME			
PHARMACY STREET ADDRESS			
PHARMACY CITY STATE ZIP			

DRUG TO BE AUTHORIZED

DRUG NAME	STRENGTH	DIRECTIONS

DIAGNOSIS OR CONDITION TREATED BY THIS DRUG

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.

APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or

suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Minimal Services
According to CPT 2001, when client's visit does not require the presence of the physician, but services are provided under the physician's supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Protocols
Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must by updated and approved by a physician at least annually.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing
Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a "reference lab" for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected to bill Medicaid for the lab service. Medicaid does not cover lab services when they are billed by the referring provider.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Restricted Card
When utilization of services is excessive, inappropriate, or fraudulent, a client is restricted to designated providers.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Routine Podiatric Care
Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

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